GEORGIA DEPARTMENT OF COMMUNITY HEALTH

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STATE OFFICE OF RURAL HEALTH
Advisory Board Meeting Minutes
Wednesday, September 26, 2007
SORH Office – Cordele, Georgia

Presiding:	Stuart Tedders, Secretary
Present:	Charles Owens, Ex-Officio Steve Barber Jennie Wren Denmark Mary Ann Shepherd William Kissell Carlos Stapleton Greg Dent William Bina, MD
Absent:	Kevin Taylor Cindy Turner
SORH Staff:	Tony Brown Sheryl McCoy Patsy Whaley
Visitors:	Tami Lichtenberg, Technical Assistance and Services Center, Program Manager Emily Nicolson, Technical Assistance and Services Center, Program Manager Elvina Calland, Department of Community Health Shawn Walker, Department of Community Health

Opening Remarks

The regular scheduled meeting of the State Office of Rural Health (SORH) Advisory Board meeting was held on Wednesday, September 26, 2007, at the State Office of Rural Health, Cordele, Georgia. In the absence of Chairman Kevin Taylor, the meeting was chaired by Stuart Tedders, Advisory Board Secretary.

Charles Owens began the meeting with a few remarks. He introduced the revised *Rural Health Plan Book* that was recently compiled and completed with facilitation by the Georgia Health Policy Center. He asked the members to review the book and inform the SORH office of its usefulness. The book will be disseminated from the SORH office and will also be available in electronic format.

Mr. Owens's shared that Cheryl Shedd and William (Bill) Kissell have resigned from the SORH Advisory Board because of professional job changes which will prevent them from fulfilling their service requirements.

Stuart Tedders shared that the Georgia Rural Health Association (GRHA) met last week. Mr. Tedders accompanied his students from Georgia Southern to the meeting. Students from various academic facilities in Georgia presented posters reflecting various projects on community research and community engaged efforts. The posters were judged at the meeting. The theme of the GRHA meeting was *Making Rural Health 2010 A Reality in Georgia.*

Mr. Owens reminded the Board members there are now three vacancies on the board. He encouraged the Members to send recommendations for potential Board members to the SORH office. Please refer to the SORH Advisory Board Members map and try to keep geographic and medical professional diversity in mind as you make your recommendations.

SORH Advisory Board Minutes:
The minutes of the June 6, 2007 meeting were approved as submitted.

Charles Owens introduced Tami Lichtenberg and Emily Nicholson, from the Rural Health Resource Center and are Program Managers for the Technical Assistance and Services Center (TASC), Duluth, Minnesota. They manage and oversee 45 state FLEX programs that support 1283 Critical Access Hospitals. They visit all FLEX grantees every three years.

Tami Lichtenberg shared background information relating to TASC. They support FLEX hospitals with current information, resources, technical assistance, and be available to answer questions about all the aspects of the program. Until recently, they were considered an entity of the Federal government, but now have a cooperative agreement grantee relationship.

Emily Nicholson further explained they no longer function as an agent of Health Resources Service Administration (HRSA) and the only difference is the governing structure. She stated about 50% of funding comes from HRSA and they are still very much connected. She commented that the current status of the State Office of Rural Health and our State's focus on rural health is positive and impressive. It is exciting to see that Georgia is focusing on the integration of Federally Qualified Health Centers (FQHCs) and hospitals on the front end of the spectrum.

Emily Nicholson gave a slide presentation about the function of the Rural Health Resource Center and the TASC program:

- A private, Non-profit entity located in Duluth, Minnesota
- Seven federal contracts
- Provide technical assistance, information, tools and resources for the improvement of rural health care as a national rural health knowledge center
- The Medicare Rural Hospital Flexibility (FLEX) Program was established by the Balanced Budget Act (BBA) – 1997, the Balanced Budget Refinement Act (BBRA) – 1999, Benefits Improvement and Protection Act (BIPA) – 2000, and Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA)
- Georgia has 35 Critical Access Hospitals (CAH) as related to Kansas with 84, Iowa-82, Minnesota-80, Alabama-4, and Massachusetts-4
- Key components of the FLEX program for 2007 Grant program are EMS Integration, Evaluation and State Rural Health Plan
- Other focus areas include Network Development, Performance Improvement , Conversion of Hospitals, Community Development, Leadership, Workforce, Health Information Technology (HIT), Access to Capital
- TASC is an arm of the FLEX Monitoring Team – creates measurement to prove FLEX program is providing results

- Pending challenges are maintaining CAH status, funding, building a national identity, and HIT implementation

The TASC has completed a CAH HIT survey and the full report of the national results can be viewed at http://www.flexmonitoring.org/documents/BriefingPaper11_HIT.pdf. The Georgia specific information is available at http://www.ruralcenter.org/hit/ga/.

Further information was shared with the Board related to Rural Health in the Digital Age and Consumer-Driven Health Care. Consumer-Driven Health Care is bringing a profound change and is driven by high costs, growing quality and patient safety concerns, new demands for transparency, and more informed/demanding consumer. Information related to the Performance Management Systems revealed 3 distinct dimensions:

- **Strategies** – Make strategy the central organizational agenda
- **Focus and Alignment** - Have resources and activities aligned with strategies
- **Organization** – Provide the logic and architecture to link all departments and employees behind strategies

Steve Barber pointed out that with the current reimbursement margin, it is difficult to keep the cash flow enough to maintain or enhance the facilities. With the present Care Management Organization (CMO) in place the contract is about 85.6% reimbursement. Since Medicare and Medicaid are the predominant payors for rural hospitals, they have the potential for funds to dry up.

Emily shared they deal with the federally related issues for the most part, and it is enlightening to know the issues state related to better plan their programs. She stated that only about 17 states provide CAHs cost –based reimbursement. She stated they will relay the issue to the National Association for Medicaid directors for them to research.

Tami Lichtenberg identified that Georgia's swing bed ratio is lower than national ratio. She related that hospitals can profit on swing beds but sometimes providers are afraid because of the documentation requirements. She stated that there are consultants willing to provide technical assistance relating to swing beds.

Elvina Calland commented that Georgia was one of the latter to come on board with the CMO program. If it is as dismal as has been discussed it will probably continue to grow worse in the future. She asked, "What are you seeing nationwide in other rural areas."

Tami Lichtenberg shared that one problem is that the main focus has been on the Medicare portion, and they have not obtained sufficient data on the Medicaid portion. She assured the Board they will urge the FLEX monitoring team to study that issue. She informed them of a report published about 9 years ago with Medicaid reimbursement data, but the data needs to be updated.

Elvina Calland said that a significant part of federal funding is Medicaid driven and for this to be a meaningful report, it is necessary for the Medicaid changes to be current. She stated that to add the Medicaid component to their already meaningful assistance will grow the impact of their technical assistance.

Charles Owens asked if the recent conversion of Critical Access Hospitals back to Prospective Payment Systems was primarily from the influx of industry or the increase of services; such as, adding surgery.

Emily Nicholson stated that four CAHs had converted back to PPS. She related that one town had a new plant come to town and created 500 new jobs which in turn created a greater need for healthcare services. However, there is one urban area that is paying the rural areas to convert from CAH because their wage index is affected. They feel it is important to keep the wage index high in their area.

Charles Owens remarked that so many programs are geared toward the increase in industry; a measure indicator would be helpful to see how a new industry will impact healthcare in a designated area.

Emily Nicholson indicated there is a study completed by the University of Oklahoma called Rural Health Works that states for every one dollar introduced into the healthcare sector returned $3 in other sectors, business, education and retail. They can run models with all the data provided for your specific area concerning business versus healthcare. She related this could be another partnership. A university could collect the data, and TASC would provide the community analysis part.

Charles Owens stated that the Department of Community Affairs has a pilot program in Northeast Georgia that will eventually impact the entire state encouraging the partnership of healthcare and industry.

Emily Nicholson gave a brief overview of the Health Information Technology (HIT) Grant. The awardees were those who already had hospitals in place who were ready to implement the program.

Charles Owens responded that Georgia was required to issue a competitive grant for the selection of CAH HIT Network. He suggested that a smaller state funded grant would be available in the future so that we might be able to have network in place should additional federal funds become available.

Patsy Whaley gave an overview of the Quality Improvement Program of the FLEX Program. She explained that the Quality Improvement Program funding is through the Georgia Hospital Association Research and Education Foundation. The program has been building for about 5 years. The program is available to 100% of the CAHs. There are 32 CAHs now reporting to hospital Compare. The program includes hospital-based quality improvement as well as physician-based quality improvement.

Jennie Wren Denmark asked if any of the other states have branched out and allowed the Federally Qualified Health Centers (FQHCs) to participate.

Emily Nicholson replied that none of the other states have ventured out to FQHCs, but that would be a great opportunity to be a leader in that area. She expressed that would show some integration and communities could meet to talk about the data. They like to see not just things measured, but things improved. They ask the question, "What do you know about the measure and what can you do to move the measure." They are always looking for ways to involve the FQHCs."

Charles Owens suggested that it might be possible to piggyback a meeting following our next Advisory Board meeting with Vi Naylor to discuss the issue further.

Tami Lichtenberg briefed the Board on issues surrounding the Emergency Medical Services (EMS). Some states are using FLEX funding to assess their communities' trauma systems. Some hospitals are implementing Level IV and Level V trauma systems in their hospitals. Assessment teams are sometimes formed to assess EMS response in certain areas and decide performance gaps. She related that Georgia is different that many states because there are more paid people and paid services in Georgia. Some funds are used to support rural trauma team development to provide rapid trauma teams.

Charles Owens stated that the Georgia HOPE program pays for the EMS training in Georgia. He further explained that this years funding is designated to craft a web-based program for the EMS.

Patsy Whaley explained that sustainability for this year will be to an external physical analysis of hospitals business practices. They anticipate doing 15 hospitals the first year, 15 hospitals the second year and 5 hospitals

the third year. The study will include reviewing claims denials, to include data used for cost reports, appropriateness of staffing, contracts and appropriate payments.

Jennie Wren Denmark provided a report on the Migrant Program. In August Katrice Brown and Tiffany Hardin reviewed six sites for quality assurance. The sites were receptive to their visits and overall rated good. The strengths revealed marked quality improvement and chart documentation. The weaknesses revealed were in documentation of immunizations and voucher utilization reviews. The next reviews are scheduled for December, 2007.

Charles Owens gave a brief overview of the SORH office.

- SHIP grants have been disseminated to the hospitals and/or networks
- SORH grant received - $148,500
- FLEX grant received - $485,000
- CAH HIT not funded
- Rural Health Safety Net
    - Central Georgia Regional, Forsyth $321,500
    - Ty Cobb Healthcare, Royston $302,500
    - West GA Rural Health, Bremen $250,000
    - Spring Creek, Blakely $225,000
    - REACH, Greensboro $201,000
    - Three Ring Health Care, Hinesville $200,000

    TOTAL $1.5 million
- Rural Health Safety Net Phase II – July 2008
- Submitted the Alternate Non-emergency Services Providers Grant

Mr. Owens reminded the Advisory Board of the Ethics Policy that was sent to them to review, sign and return to our office. Mr. Barber commented that there are areas in the policy that need to be revised in order for it to apply to board members. Mr. Tedders stated that he also has reservations signing the policy as it is currently written.

Mr. Owens asked all the members of the Advisory Board to please mark through the areas they do not feel comfortable with and sign them for our current files. The Ethics Policy will be revised and re-sent to all the SORH Advisory Board members for another signature and filed in place of the old one.

There being no further business or public comments, the meeting adjourned at 12:50 p.m.

Respectfully,

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Kevin Taylor, Chairman/Date Sheryl McCoy, Recording Secretary/Date

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Stuart Tedders, Secretary/Date